Suicide, Psychiatrists and Therapeutic Abortion

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■ *Pressures for interruption of pregnancy by therapeutic abortion constantly increase, both for liberalization of laws and for interpreting existing law more broadly.*

There are wide variations and inconsistencies in psychiatric attitudes and practices about therapeutic abortion. Follow-up patient data are scant, but necessary. Results of questionnaires indicate that such data can be obtained, and convey the impression that patients seem to manage after pregnancy, regardless of outcome, much as they had before pregnancy.

This study indicates that the incidence of suicide in pregnant women is approximately one-sixth that of the rate for non-pregnant women in comparable age groups, implying that perhaps pregnancy has a psychically protective role.

AN UNEASY EQUILIBRIUM exists between the pressures for interruption of pregnancy and the traditional codes in opposition. This conflict is poignant and personal for both patient and physician in each case considered for therapeutic abortion.

In the larger context, therapeutic abortion is an instrument of the wish to interrupt pregnancy as against the forces—physical, social and psychological—for continuation. The number of unwanted pregnancies is always a significant one, and a study of family planning in America has shown that 16 per cent of the most recent pregnancies in married women are not wanted by the wife or husband.[6] The proportion of unwanted pregnancies rose rapidly with the number of children the couple had had, from 6 per cent in the first pregnancy to 62 per cent in the ninth.

The influences in favor of the interruption of pregnancy have inevitably grown stronger in industrialized societies and have gained great impetus in view of the widespread concern about the dangers of the population explosion. In addition, it may be pointed out that the many forces of egalitarianism in our society support the drift toward the reduction of family size. Relevant to the present issue are the improved status of women and the greater importance of women in an economic role outside the home. Also many birth control measures are unequally utilized according to class position. As a part of this trend, there are constant pressures toward liberalization of the laws concerning therapeutic abortion in California.

In the more narrow context, therapeutic abortion is a device used to interrupt pregnancy where the criteria conform to specific legal requirements, namely, where continuation of the pregnancy imposes a danger to the life of the mother, which is the criterion used in the law of California and a majority of other states. The discrepancy between California law and actual practice is well established.[10]

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In a recent session of the California legislature bills[1] were introduced to change the criteria from danger to the life of the mother to danger to the life or health of the mother and consideration of the soundness of the child.

If therapeutic abortion is considered as one element in the attempt to control the number of births or to forestall the possibility of unwanted children, then it is understandable that psychiatrists become involved in part because of their concern about rights and dignity[12] of particular individuals with whom they deal and also because of their participation in efforts toward benevolent social change. In this communication we are concerned only with the psychiatric aspects of therapeutic abortion. Indeed, therapeutic abortion is now sought more and more frequently on psychiatric grounds.

The present study arose over the concern about the lack of systematic follow-up on women who had been evaluated for consideration of therapeutic abortion (on psychiatric grounds), and who were or were not recommended for abortion and were or were not aborted. It appeared that many psychiatrists were uncomfortable with the task of deciding whether or not the patient should be aborted if she came recognizably close to fulfilling the legal criteria; and a number of psychiatrists did feel strongly enough about the matter to avoid getting involved in any way in this kind of determination. Further, it was observed that there were numerous inconsistencies in the attitudes and practices of psychiatrists who rendered these judgments, as evidenced by the presentations before therapeutic abortion committees on which the authors have served. The principal criterion for psychiatric recommendation is the likelihood of suicide as a danger to the life of the mother. The difficulty of this decision accounts in part for the lack of clear and consistent standards.

In order to clarify these issues, it was decided to embark on a pilot study to ascertain:

(1) The availability of data concerning the attitudes and practices of psychiatrists who gave opinions regarding therapeutic abortion.

(2) The availability of follow-up data on those women who had been considered affirmatively or negatively for therapeutic abortions (including those who were or were not aborted), and

(3) The risk of suicide in pregnant women.

The findings seemed to be of sufficient interest and consistency to warrant reporting as preliminary results and to justify further investigation.

The California law makes abortion a felony "unless the same is necessary to preserve her life . . ."[4] Considerations of the health of the mother or of the fetus are immaterial from a legal point of view.

Psychiatric Practices

A questionnaire designed to elicit attitudes and practices concerning psychiatric indications for therapeutic abortion was sent to 100 psychiatrists, taken at random, in private practice in northern California. Sixty-nine responded.

The most striking feature of the answers was the lack of unanimity in the attitudes and practices of psychiatrists in a matter which is assumed to have scientific criteria and legal validity. For instance, one question had to do with the opinion as to the effects of pregnancy on mental illness. Fifteen of the respondents stated that morbidity was increased, 13 felt that pregnancy imposed relatively minor stress, and 25 were equivocal or indefinite in their opinions.* In a question designed to elicit the attitudes of psychiatrists toward doing such consultations, the split was almost down the middle, with 28 disliking doing them, 29 having little or no objection, and 12 not replying. Those who did more consultations reported less dislike of doing them, and also tended to recommend abortion more frequently—a reasonably expected phenomenon. The range in number of such consultations done varied from a maximum of approximately 12 per year down to none. Further examination of the data showed that one group of five psychiatrists did about 35 per cent of the reported consultations; the remainder of the 69 seemed to form another distinct group where there was a regular distribution over a range from three who did five to eight a year, to 18 who did less than one a year.

Of the 69 replying, 20 said that they had not treated or seen genuine suicidal attempts or psychotic reactions (no distinction was made between these two in the questionnaire) in pregnant women. However, 41 replied affirmatively, while four were equivocal and four did not answer. One question inquired as to whether it was improper or inconsistent for a *therapist* of a given patient to recommend abortion. Five respondents did not answer, 18 felt it was improper and, surprisingly, 36 felt that there was no impropriety involved. Ten gave equivocal responses.

In determining what the psychiatrists felt should be the criteria for abortion, it was found that virtually all respondents reported that suicide potential and psychosis were positive indications for recommendation. Also, a major proportion felt that a history of severe postpartum or severe antecedent mental illness should be among the criteria.

The opinion that the present laws are inadequate was virtually unanimous and a wide variety of other recommendations for change was suggested. A sub-

*Some responses may not total 69 since some of the questions were not answered by all respondents.

stantial number felt that socio-economic factors, rape, incest, and extreme youth were factors which should be considered. Other indications suggested by a few were psychosis of the father, congenital diseases, problems of health and fitness and age of the mother or father, unwillingness to have children, divorce after conception, adultery and narcotic addiction.

The data reported would seem to reflect the role of the psychiatrist in that he aligns himself with so-called progressive social change, particularly in those spheres where he can show concern for the welfare and dignity of the individual as a patient or as a member of society.

Attitudes of Patients

In an effort to determine whether it is possible to obtain follow-up data on patients, a questionnaire designed to elicit directly from the patient her attitudes about therapeutic abortion was sent to the 23 patients seen in consultation by one of the authors (AJR) between 1952 and 1963. Of the 23, seven were not located, eight evidently received questionnaires but did not return them and eight returned completed questionnaires. Those that were returned gave the distinct impression of being thoughtful, articulate and detailed responses. Of the eight women who completed the questionnaires, three had received therapeutic abortions and five had not. While the numbers are not sufficient to form any substantial conclusions, the impression was conveyed that the patients generally seemed to be managing after the pregnancy, regardless of the outcome, much as they had before the pregnancy, the badly adjusted still having trouble, the more well-adjusted having less difficulty. These findings suggest that follow-up data on such patients are readily obtainable and systematic studies are therefore possible with larger numbers of patients, especially where there has been personal contact with the investigators. Arranging for follow-ups before an abortion is performed would undoubtedly facilitate these procedures.

Risk of Suicide

It has been pointed out that the major criterion for the recommendation of therapeutic abortion is the risk of suicide.

Available evidence is equivocal. Swedish studies showed eight per cent of women who killed themselves were pregnant.[2] On the other hand no suicides occurred among several large groups of women who were denied therapeutic abortion.[8,11] Observations in New York City[9,13] suggest that proportionately fewer pregnant women commit suicide than those who are not pregnant. An attempt was made to evaluate this risk in California. Accordingly coroners' records of three counties in northern California (San Mateo, Santa Clara, San Francisco) having total population of about two million were reviewed for the years 1961, 1962 and 1963. For this period, three instances of suicide by pregnant women were found. This figure was compared with the statistically predicted figure for women of child-bearing age in the three counties. From this it was determined that the actuarial "expectancy" of suicides for the group involved was 17.6, in contrast to the three found in which the woman was pregnant.

These figures were arrived at in the following fashion. It was found that there was a total of 207 suicides in the three counties in the three-year period for women in the age span 16 to 50 years. The small number of three suicides in pregnant women seemed a noteworthy item even though precise statistical analysis is not possible at this time. The comparable figure for the predicted rate has many variables relating to age groups, marital status and correct reporting of suicides. The rough figure of a predicted number of 17.6 was arrived at by a comparison of the actual amount of time that any given woman of child-bearing age is in a state of pregnancy as compared against the total child-bearing period.

The algebraic computation was as follows:

$$\frac{T \times 36 \text{ mos.}}{P \times 9 \text{ mos.}} = \frac{207}{x}$$

(T* represents the total female population in the child-bearing age, and P* represents the total live births.) Inasmuch as 207 represents the total number of suicides (age 16 to 50), x yields the predicted number of suicides for the pregnant population. The resulting figure of 17.6 is a minimal figure (it is based on the live birth rate and does not take into account pregnancies resulting in stillbirths, and interruptions from other causes) and it therefore decreases the discrepancy between actual and predicted rates. However, as against minimization on this account, the standard for the total suicides introduces error of an indeterminate nature in that the child-bearing age has been extended to 50. On the one hand this would tend to increase the discrepancy because child-bearing occurs more frequently in the lower periods of this span of years, but there is also some countervailing tendency in that the assigned child-bearing period represents a smaller proportion of the total span. In summary, precise validation requires a finer statistical analysis including division of women in the child-bearing age into married and unmarried groups, but the number of actual suicides seems to be clearly less than expected.

T* was 380,905, and P* was 129,408.

The details about the cases of suicide were meager and fragmentary inasmuch as they were obtained from the abbreviated coroners' records. However, they seemed to be sufficiently interesting to warrant description even though significant conclusions cannot be drawn from so few cases. In one case a 25-year-old unmarried pregnant woman, living alone, shot her rejecting lover and then killed herself. Another case was of a 33-year-old multiparous wife of a serviceman, who in the second trimester of pregnancy, leaped from the Golden Gate Bridge. This woman was living on a military installation and in theory had access to medical care at no cost, and yet her depression did not cause those close to her to provide psychiatric care. It was said that the ostensible reason for her depressed state was her concern about the impending separation from her husband who was about to be shipped overseas. The third case was that of a 17-year-old woman who in the last month of pregnancy jumped off a highway overpass. The scanty data disclosed that she had recently come to California, having separated from her family of origin in Hawaii, and was in an environment of some stress and rejection in her new living arrangements with her husband's family.

Discussion and Conclusions

The data obtained from the results of the questionnaires returned by psychiatrists indicate a marked lack of consistency and uniformity in the attitudes and practices of the psychiatrists who are called upon to give opinions concerning psychiatric indications for therapeutic abortion. It would appear from the good percentage of response to the questionnaire and the free expression of opinion contained therein that the survey represents an accurate appraisal of the prevailing psychiatric viewpoints. From this, it can be inferred that the question of performance of therapeutic abortion is to a large measure dependent upon the particular psychiatrist who gives the judgment and it becomes general knowledge as to which psychiatrist in a community is more liberal in his recommendations.

The extreme range of opinion represented among the psychiatrists is a far cry from the scientific objectivity that one hopes would apply to determinations affecting the life and health of patients. The range was from those who essentially never recommend therapeutic abortion to those who seem always to do so, from those who regard pregnancy as definitely increasing the incidence of mental illness to those who feel that pregnancy represents virtually no additional stress. While a fair preponderance of respondents reported having seen or treated severe reactions in the presence of pregnancy, this is not consistent with the small incidence of successful suicide recorded. It might be countered that more suicides would have occurred except for prompt psychiatric intervention or treatment in the form of therapeutic abortion; but it has also been observed that of the many women considered for therapeutic abortion, whether in fact aborted or not, very few seemed to proceed with any psychiatric treatment.[3] Further, the therapeutic abortions were done disproportionately more often in the limited number of patients belonging to the higher socio-economic groups,[7] so that this would on a statistical basis cast some doubt on the effectiveness of therapeutic abortion in preventing suicides.

The law at present deals only with the danger to the life of the mother. Should the law be amended at some future time to take into account the issue of danger to the health as well, then it would become necessary to assess the psychiatric morbidity, the incidence of psychosis during pregnancy and postpartum psychosis in assessing the danger to the health of the mother.

It has been observed[3] that the psychiatrist may be manipulated into distortion and exaggeration of the patient's disturbance, with the consequence that the clinical situation comes to approximate the requirements of the law in order to obtain the abortion desired by the patient or her physician. In some instances, iatrogenic pressures intensify symptoms so that discontent becomes illness. It might be pointed out about the issue of therapeutic abortion that it is one of the few entities in psychiatric practice in which psychiatrists readily take on the role of dealing with a symptom and the management of a symptom as a primary maneuver. This is highly contrary to the general current in psychiatric principles and it directly conflicts with trends toward giving greater freedom to patients in their movements and decision. For instance, in the management of suicidal patients, the tendency is to assume a substantial amount of risk rather than to attempt to guarantee absolutely against mishap.

One can only speculate that the willingness of psychiatrists to inject themselves into the role of decision-making about therapeutic abortion reflects some covert need. Superficially, it may perhaps represent some bending to the conscious wishes of patients and referring physicians, but one cannot feel that this is the only significant item. Perhaps it is more likely to be a projection of the psychiatrist's concern with the rights and dignity of the patient and the inadequacy of the present law.

The finding that the number of actual suicides was much less than the predicted number was surprising. Can it be assumed from this that pregnancy is a period of lessened vulnerability to stress rather than of increased vulnerability? If this is so, the

reasons invite speculation. Perhaps physiologic and instinctive factors manifest themselves in greater maternal protectiveness. On the other hand, there may be effective mechanisms of increased social protectiveness and support. The fragmentary data about the three actual cases of suicide support a contention that the pregnant woman is less vulnerable because she receives greater social protection. In the cases cited, rejection, separation and loss of support seem to be paramount. These factors appeared to be acute rather than chronic.

There are other implications. A pertinent one is that because of the lack of uniformity of psychiatric opinions, a case might be made for removing the decision entirely from the realm of psychiatric indications. If the social forces which manipulate psychiatrists into taking over this role are of sufficient strength, then perhaps this represents a trend which will be manifested by other developments. These could include translating the social needs by legislative procedure into consideration of the health of the mother as well as the (at present) exclusive consideration of life. A variety of other issues—social, medical and psychologic—might merit scrutiny, such as the intactness of the fetus, economic status, extreme youth, illegitimacy, rape, incest, broken family and the like. One might speculate further that the pressures toward facilitating the interruption of pregnancy could lead to removal of the decision from purely medical hands into a more representative body of opinion from the community at large, including others beside physicians. This would approximate the situation as it is at present in Denmark. From the point of view of psychiatrists, such a change might be welcome in that psychiatrists seem to be forced into the position of making decisions which are basically non-scientific and, in fact, often contrary to the spirit of other trends in psychiatry.

It must be emphasized that the data reported here are preliminary and serve only to identify trends. These trends should be further tested and evaluated with larger numbers of patients since data seem readily available. Patients in this study were generally cooperative and willing to give information; and any reluctance of physicians to approach them directly seemed unwarranted.

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REFERENCES

1. Assembly Bills No. 2614 and No. 2310, California Legislature, 1961. Regular session. Introduced by Mr. Knox and Mr. Beilenson, respectively.

2. Bengtsson, L., cited by Ekblad,[5] p. 94.

3. Bolter, S.: The psychiatrist's role in therapeutic abortion: the unwitting accomplice, The American J. Psychiatry, 119:312, 1962.

4. California Penal Code, par. 274.

5. Ekblad, M.: Relation of the legal-abortion clientele to the illegal-abortion clientele and the risk of suicide, Acta. Psychiat. et Neurol. Scandinav. (suppl.), 99, 1955.

6. Freedman, R., Whelpton, P., and Campbell, A.: Family Planning, Sterility and Population Growth, McGraw-Hill, New York, 1959, p. 75.

7. Gebhard, P. H., Pomeroy, W. B., Martin, C. E., and Christenson, C. W.: Pregnancy, Birth and Abortion, Harper & Brothers and Paul B. Hoeber, New York, 1958, p. 196.

8. Lindberg, B. J.: cited by Ekblad,[5] p. 94.

9. McLane, C. M.: Personal communication to the authors, Nov. 10, 1964.

10. Packard, H. L., and Gampell, R.: Therapeutic abortion: A problem in law and medicine, Stanford Law Review, 11:417, 1959.

11. Statens offentliga utredningar 1953, No. 29, cited by Ekblad,[5] p. 94.

12. Szasz, Thomas S.: The ethics of birth control, The Humanist, 20:332, 1960.

13. Weiner, L.: Personal communication to the authors, Nov. 24, 1964.